PATIENT TRANSPORTATION REQUEST **NHCP 6010/2 (REV 04-01)**

NAME: _____SSN:_____UNIT:_____DATE:_____

PATIENT STATUS:____AD___DEP___RET___OTHER___ REQUEST:___ACLS___BLS

NOK:_____ADDRESS:_____PHONE:_____

DIAGNOSIS: (1)_____ CONDITION:_____

(2)_____ TIME/DATE DESIRED:_____

PATIENT IS:_____AMBULATORY_____LITTER_____WHEELCHAIR_____ISOLLETTE

VEHICLE:___AMBULANCE___GOV___OTHER

SPECIAL REQUIREMENTS

___MONITOR___CATHETERS___IVS

___NG TUBE___ O2 SUCTION___HEP LOCK

___RACTION/CAST___RESTRAINTS

___STRYKER FRAME___CHEST TUBE

INFUSION PUMPS:

1____

2____

VENILATOR SETTINGS

___ MAKE___RATE

___IV ___FIO

___ PEEP ___PS

SPECIAL INSTRUCTIONS:_____

_____

OUTGOING TRANSFERS:

ATTENDING PHYSICIAN:_____

PHONE:_____ WARD_____

ACCEPTING PHYSICIAN:_____

ACCEPTING FACILITY:_____

HOLD IN ___ER___WARD

_____

ADMISSION REVIEW COORDINATOR

_____

DISENGAGEMENT/PATIENT ADMIN.

CONTACT TRI-CARE:1-800-242-6788
AUTH#_____
ADDRESSOGRAPH INFO:

INCOMING TRANSFERS:

ACCEPTING PHYSICIAN:_____

TRANSFERRING FACILITY:_____

ATTENDING PHYSICIAN:_____

PHONE:_____

ER NOTIFIED: NAME_____PH#_____

AFTER HOURS:

_____

RESPONSIBLE PHYSICIAN DATE

_____

PATIENT AFFAIRS/ADMIN DATE

CONTACT TRI-CARE:1-800-611-2883
AUTH#_____
ADMISSIONS PERSONNEL USE ONLY:
INHOUSE___AMBULANCE___GOV___
CONTRACTED COMPANY_____
PH#_____CONTACT_____
AMBULANCE___AIR___

REFERRAL FOR CIVILIAN MEDICAL CARE

SUBMIT CHARGES TO: ☐ REFERRING UNIFORMED SERVICES FACILITY ☐ CHAMPUS

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*

ANTICIPATED LENGTH OF TREATMENT:

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED *	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

DD FORM 1 OCT 78 2161

S/N 0102-LF-002-1611

PATIENT/RESPONSIBLE FAMILY MEMBER SIGNATURE _____

SPONSOR'S FULL SSAN _____

IMPORTANT INFORMATION *(on reverse side)*